

47
Health, Welfare
Public
Service

0300
1-56

ALL
diseases in Part I must be casually related. Carer cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED AUG 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29724
STATE FILE NUMBER
6991

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bethesda Hospital				Length of stay in 1b 1 Day		STREET ADDRESS 5614 Waterman (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rolland Middle Last McFarland				4. DATE OF DEATH Month 7 Day 25 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 22, 1881	
9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Specialty Salesman		11. BIRTHPLACE (City and state or country) Cedarville, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William McFarland				14. MOTHER'S MAIDEN NAME Evangeline Iliff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no. or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 338-09-0757		17. INFORMANT Mrs. Jessie McFarland Address 5614 Waterman	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulated hernia - Gastro-intestinal hemorrhage Strangulated Hernia - gastro-intestinal hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) abdominal tumor DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 24h +	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 9-13-56 to 7-25-57 and last saw her alive on 7-25-57 Death occurred at 4:00P m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Jessie McFarland, MRS.				22b. ADDRESS 611 Olive		22c. DATE SIGNED 7/26/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE July 29, 1957		23c. NAME OF CEMETERY OR CREMATORY St. Louis Charles Cemetery		23d. LOCATION (City, town, or county) (Side) St. Louis County, Mo.	
24. FUNERAL DIRECTOR ADDRESS Drehmann-Harral 1905 Union Blvd.				25. DATE RECD. BY LOCAL REG. JUL 26 57		26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.	

(Licensed Embalmer's Statement on Reverse Side)

Dr. Thomas C. Wimber
Room 1736 Ry. Ex. Bldg.
Hours until 4:30 P.M.
Friday

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *Albert R. Thompson*

Licensed Embalmer No. *42*

P. O. Address *St. Paul*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.